OFFICE OF DR. ELLEN G. KELMAN

PATIENT INFORMATION
(please print)

Today's Date _____

Patient Name _____ Gender _____

If Under 18, parent/guardian name _____

Address _____ Apt. # _____

City _____ State _____ Zipcode _____

Date of Birth _____ Age _____

Phone (cell) _____ (home) _____

Email _____

Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )

Appointment Reminder (note: This is done as a courtesy. You are still responsible for remembering your appointment. We require at least a 24 hour notification to cancel without penalty.)

Select one type of reminder: Email ( ) Text Msg. ( ) Voicemail ( )

Preferred email or text phone number for reminder if different from above

_____

In Case of Emergency Contact: Name _____

Phone _____ Relationship to you _____

INSURED AND/OR RESPONSIBLE PARTY (If different from the patient)

Name _____ Phone _____

Address _____

Date of Birth _____ Relationship to Patient _____

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO I.D. TO THE OFFICE

Welcome to my practice.

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights about the use and disclosure of your Protected Health Information (PHI), for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. There are both risks and benefits to mental health treatment. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.
I encourage you to ask questions at all times and to be proactive with your treatment.

CONSENT TO TREATMENT

Your signature on this document gives Dr. Ellen G. Kelman permission to provide treatment for yourself or for your minor child (children). Together, we will set goals and a course of treatment. Please ask questions regarding this process at any time. Should you choose to discontinue the treatment plan or refuse to follow the recommended plan, services may be discontinued and you will be referred to another provider. By signing this consent, you will also be agreeing to report any suicidal or homicidal feelings and notify me or another authority immediately should these feelings intensify to the point where you feel unable to prevent yourself from acting on them. You understand that I may suggest you enter an inpatient treatment program for your own protection or for the protection of others. You may give consent to include your primary care physician or psychiatrist information regarding your treatment. This is voluntary and you will need to sign a separate consent form to do so.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure and locked location in my office. These records can be provided to another health care provider with your written request. Since records can be misinterpreted to untrained readers, or not kept safely, I prefer to directly transfer them myself.

CONFIDENTIALITY

Your signature on this document means that you have been advised of your rights regarding confidentiality and agree to them. As a rule, I will not disclose information about your treatment, or the fact that you are my patient, without written consent. The law (HIPAA) protects the privacy or all communications between a patient and a psychologist. HIPAA provides you with several expanded rights regarding your clinical

record and disclosures of protected health information. You can find a complete explanation of these rights online or we can discuss this further. There are important exceptions to this rule of confidentiality. Some, that you are signing consent for, but not all, are listed below:

- Administrative and billing staff may be involved in scheduling, billing, and taking your messages. All staff members have been trained in the protection of your privacy and have agreed not to release any information outside of the practice without your permission.
- Insurance companies and electronic billing services require information to process your claim. At times, they may conduct a record review. As required by HIPAA, we have a formal business associate contract with these businesses in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- Some disclosures are required by health insurers or may be given to collection agencies for overdue fees.

LIMITS ON CONFIDENTIALITY BY LAW (Situations where I am obligated to take action)

- If you threaten to harm yourself or others, I will be obligated by law to seek inpatient services, contact emergency professionals, or contact family member(s) or others who can help provide protection and safety.
- If you communicate an explicit threat of imminent serious physical harm involving a clearly identified or identifiable victim, and I believe that there is the intent and ability to carry out such threat, then protective actions must be taken. This may include notifying the potential victim, contacting the police, or seeking inpatient treatment. If such a situation arises, I will make every effort to limit such disclosure to only necessary individuals.
- If it is believed that any adult or minor child is either vulnerable and/or incapacitated, or has been the victim of abuse, deprived of medical treatment, neglect, or financial exploitation, the law requires that the appropriate authorities be notified and a report filed with the appropriate state agency. Once a report is filed, additional information may be required.

LIMITS ON CONFIDENTIALITY DUE TO COURT PROCEEDINGS

- When I have been appointed to serve in the legal capacity as a Parent Coordinator, Therapeutic Interventionist, or Expert Witness, you do not have the right to confidentiality.
- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided, such information is protected by psychologist/patient privilege.
- I will not provide information without your or your legal representative's written permission, or a court order. If records are subpoenaed, then you must consult with your legal representative, however, if ordered, records must be provided.
- If a government agency is requesting the information for health oversight activities, we may be required to provide
- If a complaint or lawsuit is filed, I may disclose relevant information required for defense.
- If a patient files a worker's compensation claim, and I am providing services related to that claim, then upon request, I must provide appropriate reports to the Workers Compensation Commission or the insurer.

TELEPSYCHOLOGY APPOINTMENTS

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychology (delivery of services using interactive audio or audiovisual systems where individuals are not in the same physical location). I am giving my consent to be treated in this manner when I request it. Phone calls, FaceTime, Skype do not provide HIPAA protection and I am using them at my own risk. A secure telepsychology website is available to me upon my request. I will not record any phone calls or sessions, in person or by way of telepsychology without written consent from Dr. Kelman.

APPOINTMENTS

My office telephone number is (480) 451-5558. If you need to change or cancel your appointment, please give at least 24 hours notice to avoid any fees. A full charge may be made if adequate notice is not given. Your insurance will not pay for missed appointments.

ROUTINE AND EMERGENCY PHONE CALLS

If you need to speak to me for any reason, I encourage you to call and leave a message. Your call will be returned at the earliest opportunity. If it is after hours and urgent, my office voicemail will instruct you as to how to leave a message on my cell phone voicemail. If it is an emergency, you need to call 911 or the Crisis Hotline 602-222-9444.

FEES AND PAYMENTS

You are expected to pay for each session at that time. Payment can be made by cash, check, or credit card. If you are using insurance, your copay or deductible is due at the time of service. We will bill your insurance for you. When obtaining benefits from your insurance, please note it is only an estimate of benefits. The actual benefit will be determined by your insurance company when the claim is received. It is your responsibility to know your mental health benefits. We will make every effort possible to release only the minimum information that is necessary. Insurance companies are obligated to keep your information confidential, however, we have no control over their practices. When you sign this agreement, you are agreeing to allow us to provide requested information to your carrier. If your account is more than 120 days overdue, we reserve the right to use a collection agency or other legal means. Should you receive payment directly from your insurance, you will be responsible for forwarding the payment to us or paying yourself.

Please note, we are happy to provide you with a copy of this agreement if desired.

I UNDERSTAND THIS AGREEMENT AND CONSENT TO TREATMENT AND AGREE TO THE POLICIES AS OUTLINED ABOVE. I ALSO AGREE TO THE RELEASE OF PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF BILLING. I UNDERSTAND MY RIGHTS TO CONFIDENTIALITY UNDER HIPAA AND KNOW THAT I CAN REQUEST A WRITTEN COPY OF THIS NOTICE.

_____ _____

Printed name of patient or responsible party Date

_____

Signature of patient or responsible party